



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Ahmed Khalifa MD

**Respondent Name**

Indemnity Insurance Co of North

**MFDR Tracking Number**

M4-17-2395-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

April 10, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

**Amount in Dispute:** \$283.16

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOB(s) and the reduction rationale(s) stated therein. Note the Coventry email dated 4/21/17 explaining the reduction rationale in detail ... Regarding 99204. Documentation does not support the level billed."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 02, 2016	Code 99204	\$251.26	\$0.00
December 02, 2016	Code 95886	\$0.00	\$0.00
December 02, 2016	Code 95910	\$0.00	\$0.00
December 02, 2016	Code A4556	\$16.90	\$0.00
December 02, 2016	Code A4215	\$15.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1 sets out the guidelines for medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 150 – Payer deems the information submitted does not support the level of service
  - P12 – Workers compensation jurisdictional fee schedule adjustment
  - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
  - 234 – This procedure is not paid separately
  - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
  - P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement

## **Issues**

1. Does the documentation support billing CPT Code 99204 in accordance with 28 Texas Administrative Code §134.203?
2. Is the allowance of HCPCS code A4556 included in the allowance of another procedure performed on the disputed date of service?
3. Is the allowance of HCPCS code A4215 included in the allowance of another procedure performed on the disputed date of service?

## **Findings**

1. 28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

CPT code 99204 is defined as “Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.”

A review of the submitted medical report does not support the documentation requirement which require the 3 key components for code 99204.

In addition, on the disputed date of service, the requestor billed for CPT code 99204, 95910, 95886, A4215 and A4556.

Per 28 Texas Administrative Code §134.203(a)(5), the Division referred to Medicare’s coding and billing policies. Per Medicare fee schedule, CPT code 95886 has a global surgery period of “ZZZ” and code 95910 has “XXX.”

The National Correct Coding Initiative Policy Manual, effective January 1, 2016, Chapter I, General Correct Coding Policies, section D, states:

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure... Procedures with a global surgery indicator of “XXX” are not covered

by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

The Division finds that the requestor did not identify a significant and separate E&M service to support billing CPT code 99204 in conjunction with CPT codes 95886 and 95910. In addition, the requestor did not append modifier 25 to CPT code 99204 per the correct coding guidelines. Therefore, the Division finds that the requestor’s documentation did not support billing CPT code 99204. As a result, reimbursement is not recommended.

2. Per the submitted explanation of benefits, the respondent denied payment for procedure code A4556 with reason code “234”.

Procedure code A4556 is defined as “Electrodes (e.g., apnea monitor), per pair”.

Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, reimbursement is not recommended.

3. Per the submitted explanation of benefits, the respondent denied payment for procedure code A4215 with “97, 45 and PS”.

Procedure code A4215 is defined as “Needle, sterile, any size, each”.

Medicare policy finds that procedure code A4215 has a status code “X” – Statutory exclusion which means:

These codes represent an item or service that is not in the statutory definition of “physician services” for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services. Service code is not covered by Medicare.

28 Texas Administrative Code §134.1 (e) states “Medical reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with:

- (1) the Division’s fee guidelines;
  - (2) a negotiated contract; or
  - (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.
- (f) Fair and reasonable reimbursement shall:
- (1) be consistent with the criteria of Labor Code §413.011;
  - (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
  - (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 Texas Administrative Code §134.203 (f) states “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

Therefore, no additional reimbursement is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

_____	_____	5/5/2017
Signature	Medical Fee Dispute Resolution Officer	Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**